General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Ltd, Balmoral Gardens, GILLINGHAM, Kent, ME7 4PN

Pharmacy reference: 1104283

Type of pharmacy: Community

Date of inspection: 31/07/2024

Pharmacy context

The pharmacy is next to a surgery in a largely residential area in Gillingham town centre. It provides NHS dispensing services, the New Medicine Service, flu vaccinations, blood pressure checks and the Pharmacy First. It also uses patient group directions to supply chlamydia treatment and oral contraceptive medications. The pharmacy supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. The pharmacy's opening hours have recently changed.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy appropriately identifies and manages the risks associated with its services to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. The pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. People can provide feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people. The pharmacy has some measures to protect people's personal information.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). The pharmacy manager said that team members were in the process of reading and signing them to show that they understood and agreed to follow them. Team members' roles and responsibilities were specified in the SOPs. Team members said that they would inform the pharmacy's head office if the pharmacist had not turned up. They knew which tasks they should not undertake before the responsible pharmacist (RP) was on the premises. And they knew that they should not hand out dispensed items or sell pharmacy-only medicines if the RP as absent from the premises.

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns by the pharmacy's head office. Learning points were also shared with other pharmacies in the group. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong quantity of a medicine had been supplied to a person. The pharmacy manager said that team members were reminded to double check the quantities while dispensing.

Workspace in the dispensary was free from clutter and there were clearly marked areas for dispensing and checking medicines. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. A quad stamp (clinically checked, dispensed, accuracy checked and handed out) was used and team members initialled next to the task they had completed. The pharmacy manager was an accuracy checker. She knew that she should only check prescriptions that had been clinically checked by the pharmacist. She said that she did not check prescriptions for Schedule 2 controlled drugs (CDs) or higher-risk medicines.

The pharmacy had current professional indemnity insurance. The right RP notice was clearly displayed, and the RP record was completed correctly. CD registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were largely completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an

emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacy manager said that she would ensure that the private prescription and emergency supply records were completed correctly in future.

Confidential waste was removed by a specialist waste contractor, computers were password protected and people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Team members had completed training about protecting people's personal information.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. The pharmacy manager said that there had not been any recent complaints. She said that the pharmacy's head office would inform her about any complaints received by them. She said that she would investigate the complaint and send any relevant documentation to the pharmacy's head office.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. Team members had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. They could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any recent safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to help maintain their knowledge and skills. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety. Team members can make professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one accuracy checking dispenser (who was also the pharmacy manager), two trained dispensers and one trainee dispenser working on the day of the inspection. Team members explained that the holidays were staggered to ensure that there were enough staff to provide cover. There were contingency arrangements for pharmacist cover if needed. The pharmacy was slightly behind with its dispensing. Team members said that this was due to recent unplanned staff absence and a change in the pharmacy's opening hours. There was an organised system which allowed team members to find prescriptions easily.

Team members appeared confident when speaking with people. One, when asked, was aware of the restrictions on sales of medicines containing pseudoephedrine. She would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Team members asked people relevant questions to establish whether the medicines were suitable for the person.

The pharmacy manager said that team members were provided with some ongoing training. The pharmacy manager was enrolled on the NVQ level 3 pharmacy course. And one of the dispensers was on an accuracy checking course. Team members said that training had to be completed in their own time. The pharmacist was aware of the continuing professional development requirement for professional revalidation. He said that he had recently completed training about emergency contraception, oral contraception, inhaler techniques and he had done the online flu vaccination training. He said that he felt able to make professional decisions. And he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members said that they received informal ongoing feedback from the pharmacist and pharmacy manager. They felt comfortable discussing any issues with them as they arose. The pharmacy manager said that the regular team meetings had been temporarily stopped due to the recent changes to working patterns. But she said that these would be started again soon. Team members said that important information was passed on informally during the day and it was also shared on the pharmacy's group chat. The pharmacy received a regular newsletter from its head office.

Targets were set for the New Medicine Service and the Pharmacy First service. Team members said that the pharmacy usually reached its targets. And the services were provided for the benefit of the people using the pharmacy. The pharmacist said that he would not let the targets affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was bright, clean, and tidy throughout which presented a professional image. And it was secured against unauthorised access. Air conditioning was available, and the room temperature was suitable for storing medicines. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. But there were some pharmacy-only medicines potentially accessible to the side of the medicines counter. Following the inspection, the inspector received a photo showing how a display unit was being used to restrict access to these medicines.

Some bags of dispensed medicines were not kept securely to the side of the medicines counter. And some people’s personal details could be viewed from the shop area. Team members put the bagged items in baskets which restricted access to these medicines, and it obscured the information on the bags. A retractable barrier was available to use to one side of the counter. This was not in use at the start of the inspection, and team members said that people sometimes came past the counter to speak with team members. The barrier was used for the remainder of the inspection. And team members provided assurances that the barrier would be used in future to restrict access behind the counter.

There was seating in the shop area for people waiting for services. The consultation room was accessible to wheelchair users and was accessible from the dispensary and shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. And people who get their medicines in multi-compartment compliance packs receive all the information they need to take their medicines safely. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. The pharmacy highlights prescriptions for higher-risk medicines so there is an opportunity to speak with people when they collect these medicines.

Inspector's evidence

There had been a recent change to the pharmacy's opening times. The pharmacist said that team members had been informing people verbally and had been including a notice with the new opening times in with dispensed medicines. There was step-free access into the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The pharmacy could produce large-print labels for people who needed them.

Prescriptions for higher-risk medicines were highlighted and the pharmacist said that he spoke with people about their medicines when they collected them. He said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. There were no prescriptions found for these medicines during a spot check. Dispensed fridge items were kept in clear plastic bags to aid identification. Team members explained they checked CDs and fridge items with people when handing them out. The pharmacy manager said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). Team members knew not to cover up any important information when dispensing these medicines and they said that they supplied them in their original packaging. The pharmacist said that he would refer people to their GP if they needed to be on the PPP and weren't on one. There were signed in-date patient group directions available for the relevant services offered.

Stock was largely stored in an organised manner in the dispensary. But there were some different medicines and different strengths mixed together in the same stacks which could potentially increase the chance of the wrong medicine being selected. The pharmacy manager said that the pharmacy was behind with its date checking. There were a few expired medicines found with dispensing stock during a random check. Team members said that the expiry date was routinely checked at the point of dispensing and checking before being supplied. And there was no evidence to suggest that expired medicines had been supplied. The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The pharmacy manager explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done

in response.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. The pharmacy manager said that one of the fridges had recently shown a temperature outside the recommended range and this had been escalated to the pharmacy's head office. The temperatures were monitored during the inspection, and they remained within the appropriate range. The records. Records prior to this indicated that the temperatures were with the appropriate range. The fridges were not overstocked, and they were suitable for storing medicines. CDs were stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy manager said that uncollected prescriptions were usually checked monthly, and medicines were usually returned to dispensing stock if a person had not collected their items after around six weeks. She said that this had not been done for a few months, but there were no expired prescriptions found in the retrieval system. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber.

The pharmacy manager said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The pharmacy manager said that people contacted the pharmacy if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled, but there was no audit trail to show who had dispensed and checked each tray. This could make it harder for the pharmacy to identify who had done these tasks and limit the opportunities to learn from any mistakes. The dispenser said that she would initial the packs in future. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries on a hand-held electronic device where possible. And these were recorded in a way so that another person's information was protected. If a person was not able to sign for their delivery, the driver took a photo of proof of delivery. The pharmacy could track deliveries and inform people about the status of their delivery if they asked. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids and triangle tablet counter were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. The pharmacy manager said that the otoscope was cleaned after each use. The blood pressure monitor had been in use for around two years. The pharmacy manager said that this was due to be replaced. The carbon monoxide testing machine was calibrated by an outside agency. The weighing scales were in good working order and the phone in the dispensary was portable so it could be taken to a more private area where needed. Up-to-date reference sources were available in the pharmacy and online.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.